NHS SALFORD CCG INNOVATION FUND: 12-MONTH PROJECT EVALUATION

REPORT DETAILS

PROJECT NAME	Rehabilitation & Self-Management
SPONSORING STRATEGY GROUP	Adult Mental Health / Innovation Fund

REPORT SUBMITTED BY	Leah Raffles
JOB TITLE	Project & Fund Manager
ROLE WITHIN THE PROJECT	Collecting data and reporting, overseeing the budget
ORGANISATION NAME AND ADDRESS	Greater Manchester Neshomo CIO 28 Moor Lane, Salford M7 3WX
CONTACT EMAIL ADDRESS	projectmanager@neshomo.co.uk
CONTACT TELEPHONE NUMBER	07940357113
DATE OF REPORT	30/6/2023

PROJECT DETAILS

BRIEF SUMMARY OF PROJECT *(In no more than 200 words)*	The Neshomo Hospital Linkworker, has established close working relationships with community connectors and Linkworkers (who connect with GPs and Salford CVS). The Linkworker, on the basis of an ISA with GMMH, can liaise with hospital staff in jointly planning hospital discharge arrangements for those recovering in mental health hospital/wards. There are also referrals from EIT, GMMH, CMHT, Internal referrals (when the outreach worker recognises that the client needs more support), and private referrals. There is always a clinician involved; the Linkworker is an experienced mental health professional who assesses the patients and supervises the project. The relationship between patient and a trained and supervised Support Worker leads to the creation of a plan to recognise and manage symptoms, develop a rehabilitation & safety plan; to develop skills and increase participation meaningful activities that suit their individual needs. The Worker may accompany the patient to these activities. Based on the trust in that has developed between Worker and patient, the Worker will be able to help the patient overcome their initial anxiety and to maintain the relationship and monitor their progress. Since the start of the project there has been over 800 hours of 1-1 support.
ORIGINAL PROJECT OBJECTIVES	
OBJECTIVE 1	Be involved with the care of 15-20 individuals, and reduce the need for hospital re-admission among that target group
OBJECTIVE 2	Reduce need for high doses of medication

OBJECTIVE 3	Increased compliance with medication
OBJECTIVE 4	Increase participation in groups or activities
OBJECTIVE 5	
[ANY OTHER OBJECTIVES]	

PROJECT TEAM

TEAM MEMBERS & JOB TITLES	Estelle Gillis – Link Worker – project lead Debra Frazer – Support Worker and Supervisor Jodie Pereira – Support Worker Michael Price – Support Worker (left end Feb 2023) Benji Sassoon – Support Worker (left end Jan 2023) Osher Sternbuch – Support Worker (from March 2023) Mindy Porgusz – Support Worker (from March 2023) Hilary Adler – Support Worker Leah Raffles – Project & Budgeting Manager Elisheva Kahan – Administrative Support Neil Joseph – Volunteer Support Worker (from March 2023)

1: INNOVATION FUND PROJECT CLOSURE

A) Was your pilot project completed by its intended 12-month end date? *If not, what were the barriers to this and how have these been overcome?*
No – we had a 5 month extension to complete the project due to delays in receiving referrals and, as we moved forward, we identified the need to put more Support Workers in place. The funding also did not arrive until May 2022. We therefore applied for a variation in February 2023, which was granted, and a new end date agreed for the end of July 2023. We have been able to put in place more robust referral systems so that patients did come through and this put us back on track. Indeed, we have now delivered all our activities by the end of June 2023.

B) Are there any activities still outstanding for delivery on this project? *If so, please describe what they are, when they will be completed and what the impact of this will be on your results and recommendations described in this report.*
No

2: DATA AND OUTCOMES OF YOUR OBJECTIVES

Note: *5 Objectives boxes are provided as default: Please delete any that are unnecessary, or copy & paste boxes for any additional objectives*

<table>
<tr><th colspan="2">OBJECTIVE 1:</th></tr>
<tr><td>A) To what extent did you achieve the anticipated outcome/s of this objective?
(Please place an 'X' in one of the boxes on the scale)</td><td>Be involved with the care of 15-20 individuals, and reduce the need for hospital re-admission among that target group
<table><tr><td></td><td>Significantly Exceeded</td></tr><tr><td>X</td><td>Somewhat Exceeded</td></tr><tr><td></td><td>Achieved as Expected</td></tr><tr><td></td><td>Somewhat Underachieved</td></tr><tr><td></td><td>Significantly Underachieved</td></tr><tr><td></td><td>N/A / Objective dropped</td></tr></table></td></tr>
<tr><td>B) Please provide any data you have collected in support of these outcomes

(Where tables and charts are presented, please provide some accompanying interpretation of what the data are showing)</td><td>[Please present any quantitative data in tables or charts, clearly labelled as to what has been measured. At least a few sentences of interpretation are also required to explain what is being shown in regard to the outcomes. File attachments to external reports, or qualitative data such as case studies, are encouraged where possible]

Several pieces of quantitative data were collected and are presented in an addendum to this report. They show significant improvements for the cohort of patients across several measures, backed up by qualitative data in comments from evaluation and several case studies, also included in the addendum.

The evaluations for the project evidence improvements in self-efficacy, mood, ability to decide own future; ability and confidence to make positive life choices; reduction in social isolation, stress and anxiety; improvement in overall mental health and overall well-being. The data analysis is attached, which includes both quantitative and qualitative data. It is worth noting that this evaluation was also used for a second project where we were a partner organisation, hence it mentions other providers in question 1. The analysis does, of course, only reflect patients supported by Neshomo. It is worth noting that one patient had also received support from another service (Jewish Action for Mental Health) in the same period.

Whilst we did not collect quantitative data related to the outcome of reducing paranoid beliefs, we did collect case studies for half of the cohort (most of whose journeys have been completed), two of which evidenced such a reduction – see case studies 3 & 9.

Across the project, no patients have either required readmission or admission to a psychiatric unit. This includes patients who have:
Recently been discharged from a psychiatric unit and are not yet under the CMHT, but are under a clinical team and are receiving Neshomo support
Historically been in a psychiatric unit and are under CMHT, and are receiving Neshomo support</td></tr>
</table>

	• Been referred, not ever having been in a psychiatric unit. The only psychiatric hospital case ongoing is one where we are supporting a patient in the unit.
C) How do these results compare to your intended outcomes for this objective?	*[Were these expected or unexpected results? Include discussion of any unanticipated results (positive or negative), and any known or proposed reasons behind your observed outcomes (especially where results have been variable).]* We supported 30 people in total. This includes 6 now discharged, 14 who are receiving ongoing report, 6 pending referrals and 4 who didn't meet our criteria. Thus we can clearly say that we cared for 20 individuals. We can also say clearly that, with no patient requiring hospital re-admission, we achieved our intended outcomes for this objective.

OBJECTIVE 2:	
A) To what extent did you achieve the anticipated outcome/s of this objective? *(Please place an 'X' in **one** of the boxes on the scale)*	Reduce need for high doses of medication [ ] Significantly Exceeded [ ] Somewhat Exceeded [X] Achieved as Expected [ ] Somewhat Underachieved [ ] Significantly Underachieved [ ] N/A / Objective dropped
B) Please provide any data you have collected in support of these outcomes *(Where tables and charts are presented, please provide some accompanying interpretation of what the data are showing)*	*[Please present any quantitative data in tables or charts, clearly labelled as to what has been measured. At least a few sentences of interpretation are also required to explain what is being shown in regard to the outcomes. File attachments to external reports, or qualitative data such as case studies, are encouraged where possible]* We did not collect quantitative data specifically related to this outcome as we were more focused on compliance in this regard. What we did collect was in case studies for half of the cohort, of which two evidenced reduced levels of medication (see case studies 7 & 10) and three became stabilised on an appropriate level of medication (see case studies 1, 7, & 8) with one coming off medication altogether (see case study 6).
C) How do these results compare to your intended outcomes for this objective?	*[Were these expected or unexpected results? Include discussion of any unanticipated results (positive or negative), and any known or proposed reasons behind your observed outcomes (especially where results have been variable).]* We recognise that we need to improve our collection of data related to medication, which currently may only be found in psychiatric reports. We will look to include this in the future in referral notes and assessment and ask for feedback from patients at review.

OBJECTIVE 3:	
A) To what extent did you achieve the anticipated outcome/s of this objective? *(Please place an 'X' in **one** of the boxes on the scale)*	Increased compliance with medication [ ] Significantly Exceeded [X] Somewhat Exceeded [ ] Achieved as Expected [ ] Somewhat Underachieved [ ] Significantly Underachieved [ ] N/A / Objective dropped
B) Please provide any data you have collected in support of these outcomes *(Where tables and charts are presented, please provide some accompanying interpretation of what the data are showing)*	*[Please present any quantitative data in tables or charts, clearly labelled as to what has been measured. At least a few sentences of interpretation are also required to explain what is being shown in regard to the outcomes. File attachments to external reports, or qualitative data such as case studies, are encouraged where possible]* Data collected from feedback shows that reported compliance with medication improved considerably across the cohort. As the data shows, 100% reported an improvement (in the positive domain, see below) after support, compared to 76.9% before. The case studies and qualitative feedback did show several patients reporting improvements for this objective.
C) How do these results compare to your intended outcomes for this objective?	*[Were these expected or unexpected results? Include discussion of any unanticipated results (positive or negative), and any known or proposed reasons behind your observed outcomes (especially where results have been variable).]* To achieve this level of impact is excellent. However, this was not perfect – the positive domain is 6, 8 or 10 on the scale 0-10 – and although 70% gave 8 or 10, just over 30% gave a rating of 6. We recognise that we need to improve our collection of data related to medication, which currently may only be found in psychiatric reports. We will look to include this in the future in referral notes and assessment and ask for feedback from patients at review.

OBJECTIVE 4:	
A) To what extent did you achieve the anticipated outcome/s of this objective? *(Please place an 'X' in **one** of the boxes on the scale)*	Increase participation in groups or activities [ ] Significantly Exceeded [X] Somewhat Exceeded [ ] Achieved as Expected [ ] Somewhat Underachieved [ ] Significantly Underachieved [ ] N/A / Objective dropped
B) Please provide any data you have collected in support of these outcomes *(Where tables and charts are presented, please provide some accompanying interpretation of what the data are showing)*	*[Please present any quantitative data in tables or charts, clearly labelled as to what has been measured. At least a few sentences of interpretation are also required to explain what is being shown in regard to the outcomes. File attachments to external reports, or qualitative data such as case studies, are encouraged where possible]* We had two measures relating to this objective in our Assessment & Review Wheel: Hobbies and Social Interaction & Relationships. Both evidenced significant aggregated improvements for journeys measured at the start and end of support. They are also underpinned by qualitative feedback from the evaluation analysis. The full analysis of the Assessment & Review Wheel journeys is presented in the addendum to this report.

	We also know from support workers that every patient undertook some participation in new activities or re-engaged with an activity that had lapsed.
C) How do these results compare to your intended outcomes for this objective?	*[Were these expected or unexpected results? Include discussion of any unanticipated results (positive or negative), and any known or proposed reasons behind your observed outcomes (especially where results have been variable).]* The results show as significant an increase in participation in activities than was originally intended, if not more. We recognised early in the project that a barrier to fully progressing on this objective is that patients did not want to participate in groups. Therefore, we developed a system by which each patient is encouraged to find any activity that they like or are willing to try. Then, with the support of their worker, such an activity would be brokered and patients encouraged to engage in these bespoke activities. It may be that, further down the line, especially when they have been discharged from this project into our voluntary befriending service, that they will participate in groups. Patients, previously afraid to walk outside their home, now engage in exercise by walking. Other patients have overcome their fear of dogs in order to walk outside. Another patient has developed the ability to take their own dog out for a walk, which they now do regularly. We worked on achieving self-care, such as showering regularly and getting a haircut, as well as domestic activities such as making sandwiches or cooking. One patient undertook cookery lessons alongside the support worker, another took up a hobby of embroidery. One patient undertook one-to-one art and gained enough confidence and self-efficacy to then attend an art group with a friend. Another was introduced to a knitting group, which they attended.

OBJECTIVE 5:	
A) To what extent did you achieve the anticipated outcome/s of this objective? *(Please place an 'X' in **one** of the boxes on the scale)*	☐ Significantly Exceeded ☐ Somewhat Exceeded ☐ Achieved as Expected ☐ Somewhat Underachieved ☐ Significantly Underachieved ☐ N/A / Objective dropped
B) Please provide any data you have collected in support of these outcomes *(Where tables and charts are presented, please provide some accompanying interpretation of what the data are showing)*	*[Please present any quantitative data in tables or charts, clearly labelled as to what has been measured. At least a few sentences of interpretation are also required to explain what is being shown in regard to the outcomes. File attachments to external reports, or qualitative data such as case studies, are encouraged where possible]*
C) How do these results compare to your intended outcomes for this	*[Were these expected or unexpected results? Include discussion of any unanticipated results (positive or negative), and any known or proposed reasons behind your observed outcomes (especially where results have been variable).]*

objective?	

3: ENGAGEMENT

A) Who were the key stakeholders identified for your project, and how have you involved them in the project? *(Please identify system/organisation stakeholders, as well as the patient / public / service user groups whom you intended to benefit from your project. Please include any challenges you faced with regards to engagement or partnership working, and how these were overcome)*	
Stakeholder Groups	**How have they been engaged?**
GMMH	Referrals and ongoing care planning with Community MH team; we have worked with the Home-based Treatment and Early Intervention Teams and have links with the Perinatal team, Living Well Services
Pennine Care Services	We receive referrals
Private psychiatrists	We receive referrals
GPs	We liaise with GPs and support patients in accessing care
Social Services	Liaise with them to get referrals or deal with complex family issues
Local voluntary organisations	We refer into these organisations and we support the patient to access and work with these organisations: Meals-on-Wheels; Foodbank; Paperweight; JWA; the Fed; Mind; JEWEL; JVN; Nicki Alliance; Neshomo Befriending; Recovery Academy; Six Degrees; JAMH. We convene the monthly Network meeting which has 30+ community voluntary and statutory agencies, which we can access as and when needed.
Community Activity Providers, including social prescribing	Bury College (offer short free courses) Garden Needs Teacher – Makeup artist (for individual lessons) Creative activities with various artists (individual or groups) Teacher – Mixed Martial Art Teacher – Exercise class Salford START Community Art Project
Family of Patients	Where appropriate we work with the spouses/parents or other family to support them in their caring role.

B) What were the main benefits your project realised for each of your key stakeholder groups? *(E.g. health benefits, wellbeing, reduced isolation, equality, community relations, etc.)*	
Stakeholder Groups	**What benefit did your project bring to this particular group?**
GMMH (Including Early intervention teams; Community MH team; Home-based Treatment Team, Perinatal Team, Living Well Services, Inpatient Rehabilitation Unit)	Patients' recovery is quicker and more lasting; worked with them through the journey from inpatient to discharge to the care of homebased treatment (CMHT); we remain with them through all the transitions, preventing relapse and reducing demand on services, eg reducing the resources needed by GMMH for these patients.
Pennine Care Services	Patients' recovery is quicker and more lasting; reducing demand and therefore fewer resources needed by Pennine Care Services
Private psychiatrists	Patients improving through complementary support, especially the opportunity given from social prescribing as well as ongoing

	support workers.
GPs	Less demand from those with mental health issues as they have the support they need (and are not constantly going to the GP when they feel mentally unwell). Overall patients feel in better mood and are more resilient to challenges. This enables increased compliance with medication for co-morbid physical conditions.
Social Services including Children's services	Able to reduce monitoring of a family, saving significant resources, eg see perinatal case study 5.
Local voluntary organisations	By encouraging patients to access their support, who would not have otherwise have done so, and encouraging participation in their activities/program.
Community Activity Providers, including social prescribing	Clear referrals for support, with patients coming with an action plan. They can serve the patients safely and the support worker enables improved attendance to classes and greater involvement with activities. Potential for ongoing work even when the patient is no longer in the Support Project.
Family of Patients	Family is supported in their care of the patient, they can often return to work, or get respite when the support worker is with their loved one. They can be signposted to further appropriate support if needed and feel secure and mentally healthier themselves when they know their loved one is getting the support they need. Positive emotion expressed within families is shown to improve significantly the recovery of the patient and the dynamics within the family.

C) How do you intend to share or publish the results of this project, and who will you share them with?

- We will be holding a sharing event in November 2023 where we will invite all stakeholders – the public, families, our staff and volunteers, Local GPs and health workers, social workers, funders, partner organisations, wider statutory and voluntary sector organisations. We will make this a hybrid event in early evening to maximise attendance.
- We will distribute the report through the Greater Manchester Jewish Mental Health Network to all the 30+ organisations that are part of the network.
- We will distribute to:
    - Mental health GM ICB commissioners directly
    - Salford CVS
    - Local GPs
    - Voluntary and Statutory Sector providers of mental health services across Greater Manchester, especially those serving other ethnic communities, who may learn from this model of support
    - Senior NHS managers and clinical teams

We will put out a press release to the Manchester Evening News and local Jewish media, both before and after the sharing event.
We would also like to submit a synopsis to a peer reviewed journal and the BBC (All in the Mind)

4: FINANCES

A) What was the value of the Innovation Fund grant you originally applied for?	£55,890
B) How much of your grant did you claim in total?	£55,890
C) What was the final spend on project activity? *Please provide a breakdown*	Support Workers' Manager/Admin = 7140 Hospital Linkworker = 14300 Support workers = 16250 Initial Training = 500 Ongoing training = 500 Supervision = 640 Researchers = 5000 Activities = 3000 Recruitment = 500 On costs = 300 Support Worker expenses = 1500 Rent = 5400 TOTAL **= 55890**
D) If applicable, please account for any over/under spend	Whilst we spent more overall on this work, we have only shown spend attributable to the grant. Within this there were some elements of over/under spend but the total was as funded. We changed the way we did the activities part of the project, and this aspect cost much less than we had envisioned. On the other hand, our staff costs were considerably more than we had thought they would be as the patients needed a lot of input and there was more supervision and training than expected. We also learned that we needed a space to meet patients and do assessments and reviews, as it was not always appropriate to do this in the patient's house, therefore we started renting a space, which has had a lot of use and proved invaluable.

5. RETURN ON INVESTMENT

A) Did you conduct a Cost Benefit Analysis as part of your project evaluation?	Yes
B) If applicable, please describe any savings that have arisen as a direct result of this project	See attached Addenda with the SROI calculation that evidences a return on investment of over £8 for every £1 invested by the grant.
C) Please describe the extent to which your project has achieved the Return on Investment predicted in your original application	Our original application did not state a level of return. However, we were hopeful of achieving at least a threefold return on investment and the SROI calculation we have made far exceeds this.

6: REFLECTIONS ON YOUR PROJECT

A) How do you feel about the overall progress you have made compared to your original expectations for this project? *(Please place an 'X' in one of the boxes on the below scale)*

Significantly Below Expectations	Somewhat Below Expectations	Met Expectations	Somewhat Exceeded Expectations	Significantly Exceeded Expectations
			X	

Comments
It took a long time to get the project off the ground. We were dependent on GMMH getting the word out, which did not happen immediately, and it took time to get referrals to come though. We are aware there are still people on wards at the moment that we are not getting referrals for. We realise we have to keep on top of people and keep reminding them that we are here and the work we do. This is particularly true regarding the aspect of being culturally appropriate, and how important this is in significantly improving recovery outcomes. It hasn't always been easy to identify the particular manager who can influence the ward staff to make the referral. There are staff moving around the whole time in wards and teams as well, so we constantly needed to inform new people. Following the sharing event, we will be using that material to do presentations to wards, teams and other health professionals going forward. We had a real challenge when 2 male support workers gave in their notice, which meant that we were not able to support some people we had referrals for. We have recruited new staff, but this delayed the project at a key time. However, over the course of the project, we have seen patients manage to develop a trusting relationship with the support workers and because of this they move forward in their lives. This includes undertaking activities they would not have tired before; organising their lives and homes; becoming less scared about their condition; and understanding it better. They become less isolated and understand that there is help out there and how to access it. The patients tell us that it is really important to them that we don't just drop them after the 10 sessions; either we continue if needed or transfer them to the befriending service for ongoing support. For some people, maintaining a stable mental state has been a real achievement. This might not be fully captured in assessments, feedback or statistics, but it changes the life of that individual and really helps their family. For other people the change has been transformative, with sustained improvements in wellbeing, increased participation and, for two, going into employment. When people start feeling well they sometimes stop the medication because they think they don't need it any more. Our support helps them realise the need to stay on their medication and to consult with their clinical team before making any changes. We can be extremely happy and satisfied with the outcomes from this project and see it as a great success, with referrals now continuing to be made. We hope that we will be able to access funding to continue its delivery.

B) Reflecting on the particular innovation you have trialled, what have you learned about what works (and doesn't) and why?
E.g. Did it work as anticipated? Did people respond to it as anticipated? How did it work? Were any assumptions made at the start of the project correct/incorrect? Were there any successes or challenges specific to the context such as area/population/condition/systems and infrastructure?

What have you learned about what works (and doesn't) and why? – Answer in relation to the support workers from a culturally similar background as well as what they did i.e. applying basic CBT techniques and various other strategies to deal with social anxiety, thereby

facilitating activities of daily living such as shopping, visiting a coffee shop or group attendance as described below.
E.g. Did it work as anticipated? Did people respond to it as anticipated? How did it work? Were any assumptions made at the start of the project correct/incorrect? Were there any successes or challenges specific to the context such as area/population/condition/systems and infrastructure?

We found that the assessment process for the patients has not been ideal. People with severe mental health illnesses can often really struggle with the anxiety of assessments and can have poor focus and concentration. They are also often not very good at self-reflection or self-awareness of their present state or improvement. The Short Warwick, for example, doesn't really capture how a patient is, as it asks about the last 2 weeks, and many people are very variable over time. Therefore, going forward, we want to streamline and review our assessment methods to be able to better evidence their achievements.

We do ongoing training and supervision with support workers to reflect on how the support worker is engaging with the patient and review the interventions that they are offering. We have improved this over the course of the project and, as we work with someone, we will put in special training related to their particular condition (e.g. OCD, psychosis).

Having the Hospital Linkworker be available at all times if there is an emergency proved to be invaluable in preventing difficulties becoming crises.

Throughout the project we were able to make sure that each patient was treated as an individual, with interventions that were tailored to them. Even with a Jewish support worker it still took time to develop trust and we learned that we need to be very flexible to support the patient according to their needs.

Some of our religious patients only wanted someone as religious as them and who spoke Yiddish. Fortunately we were able to recruit someone who met these particular needs. Some people are very stuck in their ways and, despite all the support for them, there was limited change. Although this was somewhat disconcerting, it was only a couple of individuals and we did see that they were stable, so we recognised that this was still an achievement.

We have started peer support with anonymised case discussions. This enables learning to be promulgated across all the support workers.

When the Hospital Linkworker used a specific intervention that support workers were not familiar with, we used it as a learning opportunity to increase their skills. A good example was when the Hospital Linkworker implemented 'relapse prevention' with a patient and the support worker was present and learnt this for future patients.

We have been mindful of the risks inherent in undertaking this work both for the patient, if they are at risk of self-harm or suicide, or the workers, such as where a patient has psychotic episodes or paranoid ideas. It was vital that the workers were well trained in risk management and were not shy to reach out for help if unsure of best approaches to take. This involved creating an open, transparent and encouraging environment for everyone, which was appreciated across the staff team.

7. SUMMARY: CONCLUSIONS & RECOMMENDATIONS

A) What summary conclusions, if any, can you draw about the impact/changes/outcomes which have happened as a result of this project?

1. With the first objective of the project being, "Reduce the need for hospital re-admission," the fact that no patients have either required readmission or admission to a psychiatric unit is clear evidence of success, going beyond what could have been expected.
2. There is clear value from using an assessment wheel leading to personal action planning as tools to give clarity and focus to people who often are experiencing chaotic or complex situations.
3. Having an individual to support, respect and not judge patients, from their own cultural and religious background, increases the trust in the relationship and reduces stress, anxiety and other struggles. Particularly for hard to engage with individuals.
4. Giving increased one-to-one and group opportunities through social prescribing to build social interactions and relationships, helps build resilience and self-confidence.
5. Practical support such as with benefits, housing and accessing employment, aligned with mental health support, produces real change in people's lives e.g. moving (back) into work or volunteering.
6. Regular support encourages people to raise their aspirations and keep motivated to realise them.
7. Opportunity to reflect with a support worker enables people to make positive choices about their future and increases their confidence in making positive choices about their life.
8. The intense support given is strongly evidenced to improved mood and, subsequently compliance with medication, recognising and managing symptoms and managing daily life. This appears to create a virtuous cycle, which should be a clear aim for replicating such work.
9. The Social Return on Investment, even with a pragmatic calculation, is over 8:1, evidencing considerable value from the investment, indicating that such a project should be continued and, where possible, expanded.

B) What recommendations can you make about how you or others could carry out similar projects in the future?

1. Use workers that are the same religion/culture/language to minimise trust issues and miscommunications and speed up relationship building.
2. Good communication with the referring body and the clinicians is essential to maintain smooth running of the project.
3. Maintaining good communication with the family, and seeing them as part of the wider picture for the patient, helps to embed improvements and, wherever needed, giving family members access to appropriate support can also help.
4. Maintaining good relationships with other community organisations that might offer support

to the patient or the family, means much smoother referral and access to other services in areas such as housing, benefits, therapy, volunteering and employability.

5. Opportunities to exercise choices both within home life and through social prescribing should be given to patients to embed progression with having control within their life.
6. Identifying the interests of each client through assessments that stimulate conversation and are not just tick boxes, enables these to be encouraged and practical steps taken to facilitate or broker them.
7. Helping individuals progress to ongoing support, such as befriending or support groups, means that improvements can be maintained.
8. The potential for ongoing work by other voluntary organisations and activity providers should be harnessed wherever possible, even when patients have completed programmes of support.
9. Investing in supervision and staff development of support workers, whose roles can be very intense and taxing, not only addresses any issues early but also leads to improved performance and reduced absenteeism and turnover. This includes training but also coaching, shadowing and other opportunities to learn and, importantly, apply that learning in their roles.
10. The expertise of a well-trained, qualified Hospital Linkworker is essential to assess and manage risks to the patient and the workers; enable early intervention for concerns; ensure continual improvement with the staff team; and maximise their performance.
11. Assessment and evaluation processes should be streamlined to minimise distress for patients and maximise their participation whilst capturing all essential evidence required for personal action planning and conveying outcomes.
12. Collection of data related to medication needs to include both compliance and a measure of change in dosage.

8. GOING FORWARD

A) What are the next steps for this innovation / project?

We intend to continue the project if at all possible, as we can see how much of a gap it fills and the real change we are making in people's lives. This will entail identifying and bidding to potential funders.

What we are hopeful of is that, as we present what we believe are outstanding results of this innovative initiative, NHS commissioners will want to find a way for it to continue.

B) What would now be required to sustain any gains made by this project (if relevant)?

Continuation funding would be the best way to sustain and build on the gains evidenced. This is true in terms of ensuring ongoing support for patients who participated during the project but also to keep in place the staff and processes that have proved so successful.

9. FEEDBACK ON THE CCG INNOVATION FUND

Given your experience of the Innovation Fund process…

A) How likely are you to consider applying for the fund again in the future if a suitable project/idea emerges? *(Please place an 'X' in one of the boxes on the below scale)*

Highly Unlikely	Unlikely	Uncertain	Likely	Highly Likely
				X

B) How likely are you to recommend the fund to your colleagues and associates in Health and Social Care? *(Please place an 'X' in one of the boxes on the below scale)*

Highly Unlikely	Unlikely	Uncertain	Likely	Highly Likely
			X	

Do you have any specific comments or feedback that you would like to offer about your experience of the Innovation Fund, from application to conclusion of project?
The fund is excellent for trialling innovative initiatives but there should be a system built in, where clear success is evidenced, for continuation funding so that such initiatives can be mainstreamed.

Many thanks for taking the time to complete this report template. Please note that all sections of this report are mandatory. Once completed, please submit your report via email to innovation.salfordccg@nhs.net